

90-Day Specialty Provider Transition-of-Care Period:

What is Transition of Care?

Transition of Care is a one-time consideration for employees of a new group to help ease the transition to plan providers and to best medically manage the conditions. The transition-of-care process is for active therapy that you are currently receiving, and requires approval by a Dean Health Plan Medical Director.

To be considered for this 90-day transition period, a new member must be in active treatment with an out-of-network specialty provider prior to your plan's effective date and have a scheduled appointment within the first 90 days of the plan's effective date.

How it works:

- You must submit the attached transition-of-care form no later than 14 days after your plan's effective date. You may submit prior to your effective date. Forms must be submitted prior to any services being rendered. Dean Health Plan's medical management will review the information supplied and will assess whether your care qualifies for a transition-of-care authorization. Submission of this form does not guarantee authorization approval for services with out-of-network providers.
- You or your dependent will be contacted by a Dean Health Plan representative regarding your transition-of-care request within 7 business days. If you are not contacted within 7 business days you should contact our Customer Care Center.
- If your transition of care is approved, Dean Health Plan will facilitate the initial prior authorization, indicating any limitations or special instructions regarding the request. You will receive a written authorization letter.

What is NOT considered for transition of care?

- Primary-care-provider visits with a non-plan provider.
- Any care rendered more than 30 days prior to your effective date with a non-network specialty provider.
- Any specialty care scheduled 90 days and beyond after the effective date of the new plan.

If you believe you may qualify, please complete and submit the attached Transition-of-Care Request Form. For any questions regarding this process, please contact our Customer Care Center.

Transition of Care Request Form

Please complete, sign and return this form as soon as possible to Dean Health Plan:

Fax

(608) 252-0879

Mail

Dean Health Plan
PO Box 56099
Madison WI 53705

<i>Employer Name:</i>			
<i>Employee Name:</i>			
<i>Enrollment Date:</i>		<i>Plan Type :</i> [] HMO [] PPO [] POS [] Other _____	
<i>Patient Name:</i>		<i>Patient Birth Date:</i>	
<i>Relationship to Patient:</i>		<i>Primary Phone:</i>	
<i>Patient Address:</i>		<i>Work Phone:</i>	
		<i>May we contact you at work?</i> [] Y [] N	<i>Best Time to Reach You:</i> [] morning [] day [] evening
<i>Description of condition and treatment in progress:</i>			
Current Providers	<i>Provider 1</i>	<i>Provider 2</i>	<i>Provider 3</i>
<i>Provider name:</i>			
<i>Location:</i>			
<i>Phone:</i>			
<i>Specialty:</i>			
<i>Last visit:</i>			
<i>Next visit:</i>			

By signing below, you consent to having a DHP representative contact you or your dependent, if applicable, regarding transition of care questions. If the care described above is for your **spouse or dependent over age 18**, a representative will contact your spouse or dependent.

Signature of policy holder

Date

Phone number

Spouse/Dependent's Name

Date

Phone Number